An Integrated Approach to Community Health: The Sarvodaya Experience in Sri Lanka

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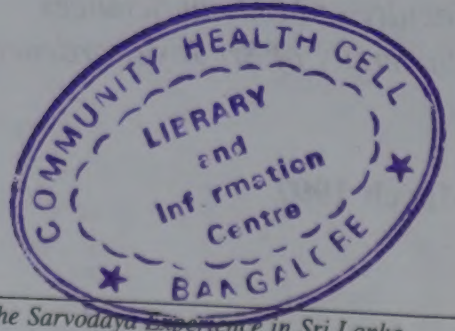


1. Summary

On the basis of conventional health indices Sri Lanka enjoys a relatively high health status compared with other developing countries with similar income levels. However, this favourable overall situation exists in parallel with morbidity and ill-health levels as high as other poor countries. Inspite of a seemingly extensive health infrastructure, the government itself admits that the health services do not fully reach those most in need such as; children, youth and adolescents, the socially and economically weak sections of society; and those living in areas covered by major development projects, plantations and areas of armed conflict.

The non-governmental organizations (NGOs) in Sri Lanka who are attempting to fill this gap also found the scale of the problem too large to have an impact on their own. However, the Sarvodaya Shramadana Movement, by far the largest indigenous NGO in the country, over a period of three and a half decades, has been able to reach an exceptionally large proportion of Sri Lanka's underprivileged communities through an integrated approach to community development. Sarvodaya has been able to motivate thousands of village communities in Sri Lanka towards self development based on the principles of sharing, community participation and planned action. An essential step in this social process is the establishment of a relatively large number of legally independent rural and urban community organizations subscribing to the Sarvodaya development philosophy, which, by acquiring a better understanding of the multiple forces and circumstances that inhibit their development efforts, gain confidence and acquire skills to act effectively on their own behalf. Sarvodaya's approach to community health is an integrated one. While organizing programmes to meet the immediate health and nutrition needs of the community, Sarvodaya lays the foundation to address the more deeper causes of ill-health, namely; poverty and powerlessness. Social programmes to satisfy the basic human needs run parallel with community level economic programmes for which functional leaders from the village itself, are trained and mobilized.

Today, these independent village level community organizations are keen on strengthening their capacity to implement comprehensive community health programmes. They have realized how important it is to take more responsibility for their own health especially in the context of environmental health threats posed by an open market economy in Sri Lanka. For this to happen there is a need to further strengthen these village organizations in their capacity to plan, implement, monitor and evaluate health programmes. This would not only ensure optimum use of community resources but also long term sustainability.

Sarvodaya does not believe that ill-health can be alleviated without a more fundamental social change to eradicate poverty and powerlessness among poor communities. The Sarvodaya infrastructure from the national level to the grass-roots form an available, effective and proven basis for meeting the health challenges of the 21st century. The village level Sarvodaya Shramadana Societies and the grass-roots level Sarvodaya workers have clearly demonstrated their willingness and ability to acquire the necessary knowledge and skills to take up the challenges through an integrated and sustainable approach to community health.

2. Background

On the basis of conventional health indices, Sri Lanka has achieved a satisfactory standard of health despite a relatively low per capita income (US $ 419). Sri Lanka has an Infant Mortality Rate of 19.4 per 1,000 live births, life expectancy of 67.8 years for men and 71.7 years for women, and a Crude Death Rate of 5.8.[1] However, this favourable situation exists in parallel with morbidity levels as high as any other developing country with a disease pattern of preventable nature. These include amongst others, maternal and child undernutrition, anaemia, diarrhoeal diseases, dysentery, acute respiratory tract infections and malaria. It is also observed that Sri Lanka is beginning to encounter the problems of ill-health such as environmental and occupational diseases, and diseases related to stress; that have emerged in the more developed and industrialized countries, even before it has succeeded in eliminating the diseases which have their source in poverty[2].

The data on morbidity and mortality in Sri Lanka are available only on a district wise basis with very little or no health data originating at community level. Moreover, the existing data are based only on hospital in-patient records and thus do not give an accurate picture of the health status of any given population subgroup. There are pockets of poverty even in districts which have favourable health indicators where mortality and morbidity levels are probably higher than in the rest of the district.[3] This problem has been identified as one of the overall issues that concerns the quality, range and coverage of health services in Sri Lanka by the recently appointed Presidential Task Force (PTF) for the formulation of a National Health Policy. The PTF report states that *"the health services do not as yet fully reach those most in need, such as children, youth and adolescents, the socially and economically weak sections of society; and those living in areas covered by major development projects, plantations and areas of armed conflict".*[4]

Although the Government of Sri Lanka has committed itself to the goal of Health for all by the year 2000 (HFA) with Primary Health Care (PHC) as the key strategy, there has been no systematic approach towards truly involving communities in the planning and implementation of community health programmes. As Karunaratna (1986) observes, "most of the services are curative and there is no single unit that provides integrated and comprehensive care for the individuals/families in the community on a continuing basis. Also there is hardly any liaison between these services and no integration of their functions".[5] Among the countries studied, Sri Lanka is one of the countries which "lack any effective system of PHC. Although there are paper schemes in theory, in practice they exist haphazardly, poorly planned and supervised and with uneven controls. Lack of resources also adds to frustrations of the people as well as the health workers leading to low morale, low-initiatives and low enthusiasm for the future".[6]

The most peripheral health worker in the health care system in Sri Lanka is the public health midwife (PHM) or the family health worker, who is a paid worker in the Ministry of Health and serves a population of approximately 3000. She is the grass-roots health worker for family health care and provides domiciliary service, mainly to mothers and infants, and maintains the link between the clinic and the community. She has a wide range of clinic based duties in addition to household visits and as such the PHM is overburdened with her routine work. Furthermore, about one-third of the average PHM's time is spent on travel to

reach her service points, increasing to one-half among more widely scattered populations. Thus, even though the PHM commands a very good rapport with and respect from the community and community based organizations, she is unable to provide continuous leadership for comprehensive PHC programmes. It is as a remedy to this situation that the government of Sri Lanka since mid nineteen seventies started training voluntary health workers (VHWs). However, the experience of the past one and half decades shows that the VHWs also in most cases ended up assisting the PHMs in their clinic based duties to relieve the latter from more mundane problems of the physical upkeep of the clinic rather than promoting preventive health care in their communities.

In the non-government (NGO) sector too, planning and implementation of most health programmes have to date been carried out on a piecemeal basis, addressing community health problems identified according to criteria set by outside donors or in accordance with the mandate of a given NGO. However, the NGOs in Sri Lanka, who serve as intermediaries to poor communities in most health related activities, have great potential to contribute towards improving PHC,[7] if systems could be developed at the community level to coordinate their activities more effectively. One such indigenous NGO in Sri Lanka is the Sarvodaya Shramadana Movement, which is by far the largest NGO in the country.

3. Sarvodaya Shramadana Movement (SSM) of Sri Lanka

In 1958, a team of high school teachers and students in Sri Lanka, selected a socially depressed and economically backward village to live, serve and learn from village people during a school vacation. This study service project, with growing number of volunteers in an increasing number of villages, developed itself into an independent national reconstruction movement known today the world over as the Sarvodaya Shramadana Movement (SSM) of Sri Lanka.[8] The Movement derives its legal status by being incorporated by an Act of Parliament as Lanka Jathika Sarvodaya Shramadana Sangamaya (LJSSS) Incorporated.[9]

Sarvodaya Movement works in all parts of the country in over 8000 poor villages, including the North and the where there is a continuing civil war. The Movement aims, through the *shramadana* camps, to bring together and integrate ideas, resources, manpower, know-how, and organizational structures from the village community level up to the international level: from village re-awakening, through national re-awakening to world re-awakening.

The methods and techniques developed by Sarvodaya in building community awareness, ensuring community participation and sustaining community management in thousands of Sri Lankan villages on a national scale has been it's greatest achievement. A significant strength of the Sarvodaya Shramadana Movement is that it has a widely dispersed set of centres, consisting of 32 district centres, 245 Divisional Centres and special training institutes, which makes its services available to even remotest of the rural communities. It has a field staff of over 900 full timers who have demonstrated their capacity to work with the people they are intended to serve. The staff are accepted by the communities of all religions and ethnic groups in all parts of the country. They also have established excellent

rapport with government extension services. This full time staff motivates, trains and helps organize thousands of village volunteers for self-development of villages.

In achieving its mission, Sarvodaya has over the years developed a multitude of programmes. Based on it's extensive field experience Sarvodaya has postulated a five-stage process of village community development (Box 1).

The first stage is that of *psychological infrastructure building*. It begins quite simply with a village level discussion about local needs and organizing self-help activities. Villages enter the second stage of *social infrastructure building* when they have formed one or more community groups, of farmers, mothers, children, youth and elders. The third stage of the Sarvodaya developmental process is a very critical one. At this stage the village is organized to *satisfy its own basic and secondary needs*. In addition the village Sarvodaya groups are brought together and institutionalized as a legally incorporated body (the Sarvodaya Shramadana Society) which is entitled to open its own bank account, obtain loans and start economic activities with support from District and National level Sarvodaya structures. Villages in the fourth stage are expected to become *self-financing* in their Sarvodaya activity and they *assist neighbouring villages* as well in their fifth stage. As village communities go through these stages the three principles of self reliance, community participation and planned action are observed. Every village community is assisted to develop itself into a legally incorporated village society. Similarly, clusters of 10 villages and then two to four clusters which make up a division and finally to 10-15 divisions which make up a district all encouraged to build themselves into legally incorporated entities.

The communities who subscribe to this development process, acquire a better understanding of the multiple forces and circumstances which inhibit their development efforts while gaining an increasing confidence and acquiring skills to act effectively on their own behalf. In Sarvodaya it is the community which makes the decisions and the role of Sarvodaya is to enhance the quality of the community-level decision making and facilitating the implementation of the decisions in various ways which include the training of village level functional leaders, skills development, and provision of technical and financial assistance (Figure 1, Sarvodaya Package for Community Participation and Self Reliance).

Sarvodaya has been hailed as an example of a successful and innovative approach to PHC.[10] This paper describes how this extraordinary people's Movement in Sri Lanka operationalizes its philosophy into effective action, the result of which is a healthy community.

Five Stage Village Development Process of Sarvodaya

The Five Stage Village Development Process

First Stage: This represents the initial stage where the community is still very loosely knit, there are no organizations to represent the community as a whole, the community lacks a sense of direction, there is disunity and egoism.

The initial self-help work inspired and supported by Sarvodaya is to bring the community together, to give them an idea that collectively they are a considerable resource as well as a power. This self-help work is referred to as building the psycho-social infrastructure necessary for the subsequent stages.

Second Stage: During this stage functional groups emerge in the community. They are the Children's group, the Youth Group, the Mother,s group, the Farmer's Group and the Elder's Group. It has been found that the Mother's Group and the Children's Group are the most prevalent and most active. The Sarvodaya field workers inter-act with the groups and development education courses are conducted at Sarvodaya filed centres and special institutes for selected members of these Groups. The village child-care centre cum community kitchen generally arises during this stage.

Third Stage: The characteristic feature of this stage is the emergence of the village-level Sarvodaya Shramadana Society (SSS) which includes all of the functioning Groups and it's registration under the Societies' Ordinance. This makes the village Society a legal entity which can sue and be sued, hold properties and other assets, open a bank account and enter into formal contracts and start their own economic enterprises to create employment and increase incomes.

At this stage Sarvodaya offers certain services which are contingent on a functioning registered society. The principle service is the initiation of economic activities starting with savings and credit schemes. The office bearers are provided with management training to run these savings and credit schemes. Another service which starts with this stage is the technological support to the village communities to improve their water supply and sanitation. This support consists of the services of professionals at village level and the supply of material not available in the village, as for example cement.

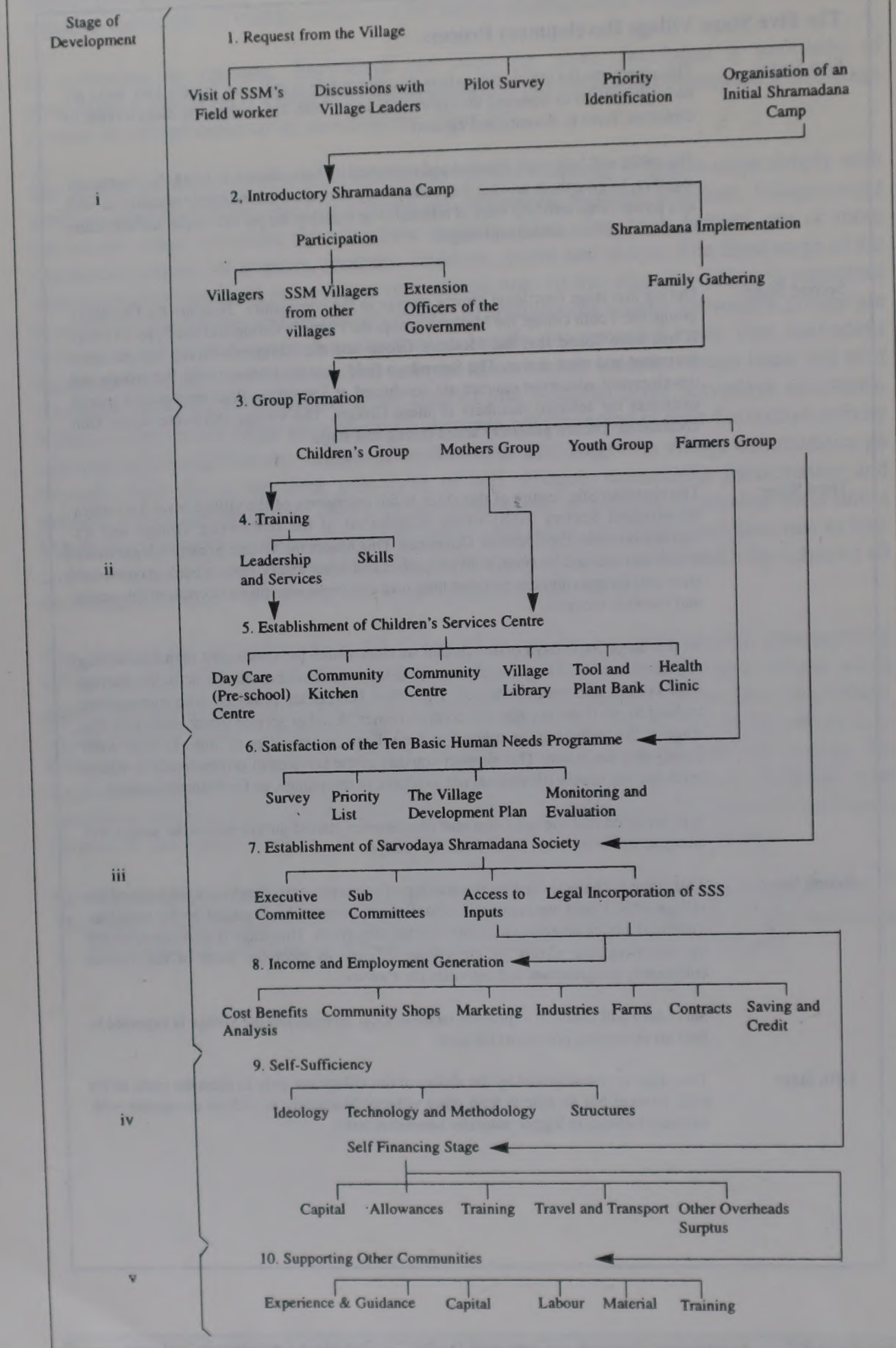
It is expected that the activities and programmes started during the earlier stages will continue but with lesser input from Sarvodaya.

Fourth Stage: This stage is characterized by the starting of economic activities under the aegis of the village SSS. Loans for economic activities are given to be managed by the societies. Technical advice on economic activities are also given. This stage is also characterized by the increasing ability of the village Society to meet the costs of the various community programmes and activities on it's own.

Sarvodaya will continue to provide technological services but the village is expected to bear an increasing portion of the cost.

Fifth Stage: This stage is characterized by the ability of the village not only to meet the costs of it's own services but be able to help other villages financially as well as co-operate with adjacent villages in bigger mutually beneficial tasks.

Figure: 1 Sarvodaya Package for Community Participation and Self Reliance



4. Overview of Main Programmes of Sarvodaya

The Sarvodaya programme structure hinges on three "empowerment processes" - or *Divisions* in administrative terms - social empowerment, economic empowerment and technological empowerment. Inserted into the overall structure are specialized services which have risen according to need and circumstance, all of which subscribe to and work in accordance with the basic Sarvodaya philosophy.

The ***Social Empowerment Division***, as the name implies, is responsible for the social awakening and mobilization of a community, leading it through a five stage development process. Basic development activities are carried out and a Sarvodaya Society formed. Sarvodaya identifies *Pioneering Villages* which, as they proceed through the five-stage process, are enabled to assist *Intermediary Villages* in entering into the development process, and subsequently *Peripheral Villages*.

Various "specialist units' have been formed as specific services required in the social awakening process are identified. Principal among these are Community Capacity Building, Early Childhood Development, Community Health and Environment, Conflict Resolution, Disaster Management, Gender and Development, Development Education and, Applied Research and Communication.

In the context of Sri Lanka's armed conflict, Sarvodaya undertakes an important Relief and Rehabilitation activity to assist government and international NGO's in their efforts,and to promote ethnic harmony and social stability in the country.

The economic empowerment arm of Sarvodaya, namely, the ***Sarvodaya Economic Enterprises Development Services (SEEDS)***, provides three types of service.

Rural Enterprises Programme (REP), is introduced to village societies with the mission to "make a sustainable development in the income of poorer members of Sarvodaya village societies and enable the village societies to fund Sarvodaya village-based development activities". New societies entering the REP are selected from among those at Stage Three. Surveys of poverty carried out by SED are used to identify the poorer families needing support. The REP itself carries out a survey of village activities in consultation with SED to assess the functioning of the village society before commencing REP activities in the village. The initiation of village-level savings and credit schemes, developing the capacity of village societies to run savings and credit schemes and managing economic activities constitute the major work under this programme. Prior to the savings and credit activities, Sarvodaya's own Management Training Institute (MTI) provides a series of training for officer bearers, members of the Executive Council and sub-committees of the village society and sub-group leaders. A change in the traditional composition of the leadership at the village level is expected to be made through such training.

The *Rural Enterprises Development Services (REDS)*, is the programme which provides the technical support to REP in agriculture, business development and product development areas. It is an essential support service for REP borrowers. REDS will also attempt to increase the dicersity of the REP credit portfolio with successful income generating activities.

The *Management Training Institute (MTI)*, provides training for two distinct groups. One set comprises personnel at village level, particularly the office bearers of the societies. The other set comprises the staff of the LJSSS and in particular the staff of REP and REDS. Its primary role is as a supporting programme for REP.

The technological empowerment arm of Sarvodaya is known as the ***Sarvodaya Rural Technical Services (SRTS)*** and it works in villages at Stages Three, Four and Five, but the major concentration of its activities is in villages at Stage Three. It provides technical services and financial assistance to village societies in relation to meeting their basic needs primarily with respect to water supply, sanitation, energy, and transport.

There are several operations which are legally and administratively independent of Sarvodaya's operational structure but which nevertheless conform to Sarvodaya's ideals. They are the Sarvodaya Suwasetha Sewa Society, the Sarvodaya Women's Forum, the Sarvodaya Samodaya Service, the Sarvodaya Legal Services Movement, and the Sarvodaya Peace Brigade.

The cardinal strategy that Sarvodaya adopts in initiating the psychological infrastucture building process is the ***shramadana camp***. The shramadana camp technique is one of the ways in which a physical and psychological environment is created in a community where men, women and children all come together, work together, sing and dance together, meditate together and discuss together while accomplishing a task in the village that benefits them such as the construction of a road, well or an irrigation canal, a soil conservation project and so on. A special feature of the shramadana camp is the ***family gathering***. The village community, volunteers from neighbouring villages and cities and government officers are invited to participate as equals at these family gatherings are present at these meetings. Seated together on the ground, this is a face to face meeting where they can share ideas, gather knowledge, surface grievances, discuss solutions to problems, plan future community actions, build awareness as to the reality of their marginality in society and get a glimpse of the new alternative egalitarian society Sarvodaya envisions. The ancient thought that the `whole humanity is one family for the wise' is lived in the shramadana camps environment breaking down all man-made barriers. It is this consciousness that has to be the foundation for a new society.

5. Sarvodaya Approach to Community Health

Sarvodaya does not believe that ill-health can be alleviated without a more fundamental social change to eradicate poverty and powerlessness among poor communities. Community health activities are therefore not generally distinguished from Sarvodaya's other integrated village development activities. They are tied directly to early childhood development programmes, most training programmes, and a variety of other development activities, making it difficult to say where "health" activities begin and where they end. However, an attempt is made in Table 1, to present the village level Sarvodaya activities coming under the main components of PHC.

As a WHO/UNICEF Report (1977) observes, *"rather than building up a separate infrastructure within the Movement, all Sarvodaya activities at village level and indeed at all levels strongly promote health. Also it should be noted that health status of Sarvodaya villages has improved significantly. At the same time, the official health services are being used more rationally. These changes have comeabout because the Movement's activities have a strong health component".*[11]

Up until 1995, Sarvodaya did not have a separate programme within its organizational structure for community health. However, under the new Sarvodaya Strategic Plan which came to effect on 1st April, 1996, a specialist unit, the ***Community Health and Environment Unit*** was formed which now coordinates with all Sarvodaya programmes providing the necessary technical support in the field of community health.

The main programme divisions of Sarvodaya, namely the SED and the SRTS, deal directly or indirectly with community health activities. It is the SED through its Early Childhood Development Unit (ECDU) which initiates community health activities in the village usually in the Second Stage of village development. They start with the establishment of a pre-school cum child development centre. Child development services usually begins in a village after the initial *shramadana* phase in which the village people donate their labour and other resources to satisfy a community need such as constructing an access road or putting up a community hall. This is followed by the formation of a mothers' group. The pre-school teacher trainees, usually 2 per village, are selected by this mothers group. They are given a preliminary two week residential training at one of the Sarvodaya Development Education Institutes, District Centres or at the Head Quarters.

After the training course, the pre-school teacher returns to her village to start the pre-school. It is the community 's responsibility to find a suitable place to conduct the pre-school. It may be a community hall, temple hall, verandah of a villager's house or the villagers may even put up a separate building using local material, depending on the level of poverty of a given village. The mothers' group provide guidance and other forms of support to the pre-school and the pre-school teacher. The pre-school is the first permanent activity in a Sarvodaya village and it becomes the nucleus of all other development activities in the village. After working in the village for 6 months, the pre-school teacher is called back for an intensive three month training course which covers in greater detail health, nutrition, first aid and development matters. At one stage, the graduates of this course were mobilized as community health workers (CHWs) to attend specifically to health matters. This was discontinued as Sarvodaya realized community health should not be separated from Sarvodaya's integrated main stream village activities. As WHO/UNICEF report observes, *"this appears to have been a logical decision in view of the fact that health promotion activities were part of most of the movement's projects".*[12]

According to the latest statistics there are approximately 4000 pre-schools served by over 6000 trained pre-school teachers who work voluntarily or supported by their own communities. Despite the shortage of resources available for the pre-school, they are extremely popular because of the services they provide.[13]

Firstly, pre-schools are secure places where village mothers can leave their children and go to work. The children enjoy being at the pre-school because they can do a lot more fun

things with like-minded toddlers than by being alone at home or with their grand parents. Secondly, the pre-school becomes a `nutrition centre' where the mid-day meal, prepared with the most nutritious locally available leafy vegetables is served. Each pre-school child contributes to his or her meal by bringing a match-box full of rice everyday. This rice is emptied into a pot each morning and is used to prepare the mid day meal. In villages where a community kitchen is a part of the pre-school, school going children as well as pregnant and lactating mothers also get a mid-day meal.

In combatting rural malnutrition, the Sarvodaya experience has shown that the long term solution to this problem to a great extent lies in the establishment of successful home gardens. Home gardening is carried out by the members of the children's and mothers' groups. The children are taught the value of what they grow. The home gardens not only meet a substantial portion of the daily nutritional requirements of the household, but also pave the way for the villagers to make an additional income by selling the surplus vegetables and fruits. Even in the short run, the villagers make an additional income by saving in the amount they usually pay for the shop-keepers.

The pre-school teacher does growth monitoring of all the pre-school children under her care. Regular maternal and child health clinics are conducted after consulting the government health workers, with whom the pre-school teacher maintains a close relationship. A basic task of the pre-school teacher is to motivate mothers through creating awareness on health matters. Actual medical examination, immunization and treatment are carried out by the government health workers. This way Sarvodaya is successfully bridging the gap that exists between communities often remote and ill-informed, and the government health services, while making the latter more responsive to community needs.

The mothers group plays an important part in this consciousness raising process. The pre-school teachers are taught basic participatory communication skills to facilitate this process. The mothers' groups are also being served by an independent national unit, The Sarvodaya Women's Movement whose objective is the "total development of a woman as a person in her own right and as a person who is prepared and equipped to play the many roles an enlightened society may expect of her".[14] The Sarvodaya Women's Movement implements a variety of projects and programmes through the mothers' groups addressing specific needs of women; especially the most disadvantaged - including street women, women prisoners and the women living along the coastal belt.

By this time, the village will have other persons in the village trained by Sarvodaya for various other community development activities; such as *shanthisena* (discussed below) and the village would have seen the emergence of the village Sarvodaya Shramadana Society, a legally independent body which would now take over the primary responsibility for self-help development activities in the village. Once it is registered as a legal entity, the village society could own land, buildings, vehicles, equipment, and receive loans and seed capital from any external agency other than Sarvodaya itself. At this stage the village receives supplementary technical and financial support from Sarvodaya in an important area of community health, namely; water supply and sanitation. This support is also channelled in such a way as to strengthen the village self reliance and self confidence. All critical decisions as to the choice of technology, levels of service, location of facilities etc., are taken by the community, in addition to their cash, material and labour contributions.

Table 1 - Sarvodaya activities under the main components of PHC

PHC Element	SSM programme	Activity
Nutrition	SED/ECDU	-child care centres/pre-schools -community kitchen -creches (plantation areas) -home gardens -nutrition education through mothers groups -training -preparation of educational material
	Suwasetha	-nutrition/feeding centres for abandoned and malnourished children
	Women' Movement	-street children's programme (in collaboration with SCF)
Water Supply	SRTS	-construction of protected wells, gravity water schemes, shallow well handpumps -technical assistance -training -preparation of technical manuals
Sanitation	SRTS	-provision of assistance for latrine construction
Maternal & Child Health	SED/ECDU	-pre-schools -community kitchens -health education through mothers groups -clinics
Immunization	SED/ECDU	-organizing clinics as part of pre-school activities -maintaining immunization records of all pre-school children -educating mothers on the value of immunization
Control of endemic diseases	Special Project	-Sarvodaya Malaria Control Research Project -Collaborative project with the Anti Leprosy Campaign
Health Education	SED/ECDP	-through pre-schools and mothers groups
	Audio Visual Unit	production of audio-visual material for health educatio
	Comm.Health Unit	AIDS education resource centre
		AIDS prevention and control programme
	NDEI	Population and Family Welfare Education Project
	Women's Movement	Environment Education
Treatment of Common Diseases	Comm. Health Unit/ Shanthisena	-first aid and basic treatment ("Suwadana" centres)
		-community/mobile medical clinics
Provision of essential drugs	Comm.Health Unit	supply of essential medicines, supplies, and equipment to areas affected by armed conflict and remote rural areas

Village savings and credit programmes are initiated at this stage as the foundation for strengthening the economic base of the village, which is an important determinant of sustaining a healthy community. The Sarvodaya Rural Enterprises Programme (REP) assist the village society to develop the capacity to run savings and credit schemes and managing economic activities. The major responsibility for managing the economic activities such as; primary credit approval, recommendations for re-scheduling and actions against defaulters are all done by the economic sub-committee of the village society.

Unfortunately, due to financial limitations Sarvodaya cannot provide the same assistance to all the villages that it has some development activity going on. Thus, these highly organized village communities have not harnessed their fullest potential in addressing community health problems. These village societies should be able to plan their own community health programmes and where necessary they should be able to approach external resources by way of writing and submitting their own village project proposals. Some Sarvodaya village societies have done this in other areas of development such as agriculture, community forestry and women's projects. The same has not happened in the area of community health. Although there are several reasons for this, one of the main problems have been the absence of an information base for the villagers to understand and profile their own health problems to take collective action and to solicit outside assistance in a convincing manner. Their overly dependent mentality of the government health services, even if such services are not readily available, compounds this problem.

While working towards removing the root causes of ill-health and long term sustainable health gains, Sarvodaya could not overlook the sickness and suffering that already exist in the community. Therefore, wherever feasible it has promoted provision of basic curative services to undeserved communities through various means which include;

- organizing regular medical clinics through volunteer doctors, nurses and physiotherapists
- providing logistical support to government medical personnel to maintain and run their regular clinics
- assisting rural hospitals in underpreviledged areas to upgrade their facilities
- provision of limited stocks of essential medicines and equipment through local and foreign donations
- establishing village level mini health posts (*suwadana* centres) run by trained *shanthisena* volunteers (see below)

Sarvodaya has several independent national units discharging definite functions which also have programmes related to health. They are;

The *Suwasetha Sewa Society Ltd*, which carries out welfare work earlier carried out by the main organization and at present runs separate homes for the malnourished children, the disabled, destitute children and the aged. It also manages the community based rehabilitation programmes (CBR) for the physically disabled and the blind in selected districts and runs a school for children with auditory defects.

In the curative side, the Community Health and Environment Unit is served by a team consisting of a full time Registered Medical Practitioner, a physiotherapist, 2 nurse assistants, under the guidance of a volunteer medical doctor trained in public health and provides specialized services across all Sarvodaya programmes. The services provided include a head quarters' based medical clinic for the full time staff, provision of medical services during emergencies and disasters, conducting medical clinics in refugee camps, ambulance service, physiotherapy clinic, and dental health services. The Community Health Division also manages the special project for AIDS prevention and control.

The *Sarvodaya Shanthi Sena Services* (Peace Brigades) which arose in response to the need to protect people during a time of intense civil strife in the early 1970s, with the easing of tensions, the youth who were mobilized were trained to undertake general services for the communities such as rendering first aid, disaster relief, assisting in the conducting of religious festivals and cultural events, hospital visits to assist the sick, environmental conservation activities etc. The groups are at village level and the members act in groups of ten with a leader. Different groups may combine for various activities. The village level work done by these groups includes the maintenance of mini-health posts and herbal gardens which are a source of home remedies. The group leaders are organized at Divisional and District levels. There are over 77,000 Shanthi Sena members already serving in the country. There is a systematic scheme of training for Shanthi Sena volunteers. The mini village health posts known as ***suwadana*** (gift-of-health) centres run by these volunteers are a very popular and beneficial activity. They are a focal point for achieving a balance between prevention and cure, and for a variety of other village level community health activities. The *suwadana* centre is usually a small room in the own home of one of the volunteers and is run and maintained by donations received from the community. Only the initial first aid instruments and medicines are supplied by the LJSSS following the training of *shanthi sena* volunteers. However, due to various constraints such as extreme poverty in some villages, lack of initial capital to buy the basic instruments and medicines, lack of proper logistical support etc., not all Sarvodaya villages have *Suwadana* centres. Sarvodaya believes that *suwadana* centres are rendering a very valuable service to the community and that this activity should be expanded to all Sarvodaya villages in Sri Lanka.

To supplement this integrated approach to community health, Sarvodaya has a number of important ancillary activities, such as promotion of indigenous medical practices, production and promotion of low-cost, smoke-free, energy saving kitchen stoves to reduce incidence of acute respiratory infections (ARI), and a programme for prevention of drug addiction and alcoholism.

The aim of the Sarvodaya Malaria Control Research Project (SMCRP) which was carried out in the 1980's was to develop a primary care approach to malaria control.[15] It was an experimental project to find the effectiveness of community level actions such as; breeding of larvivirous fish, training of village volunteers in carrying out surveys and blood screening, growing mosquito repellent plants, and use of impregnated bed nets, in controlling the transmission of malaria. The project also sought to identify and evaluate suitable indigenous practices.[16]

Sarvodaya has never been reluctant to try out new or adopt the so-called "modern" techniques and methods that would help address felt community problems, provided that they

were in line with the Movement's philosophy. Sarvodaya has demonstrated how even in the case of introduction of technology, the indigenous knowledge and traditions enabled one to mould and shape technology into an appropriate socio-culturally digestible condition.

An example is Sarvodaya's promotion of a traditional drink called *kola kenda*, which is made of green leaf extract, rice, coconut, and sugar. The nutritive value of kola kenda is highly regarded in the Sri Lankan culture. It is made of locally available leafy vegetables, and the simple machinery; the leaf juice extractor, designed by Sarvodaya to produce kola kenda, as Nichter (1988) observes "is a shining example of appropriate technology".[17]

In the 1990's Sarvodaya has intensified and diversifed its activities in the area of community health. New programmes were initiated for emerging health problems. These include activities on STD/HIV/AIDS prevention and reproductive health, programmes for addressing the problem of child mental trauma resulting from exposure to war related violence, and environmental health.

Finally, while working at the community level, Sarvodaya is also playing an active role at national level. Sarvodaya is represented in many important national bodies in the health sector which include the National AIDS Committee (NAC), National Nutrition Coordinating Committee and the National Core Group on Primary Health Care Services to the North and East. It also maintains close contacts and collaboration with international organizations such as the WHO, UNICEF, UNFPA and UNDP.

Project to develop a Buddhist approach to AIDS prevention in Sri Lanka

The role of religion in the prevention and control of AIDS has received considerable attention in recent years especially in those regions in the world where strong cultural values are influenced by the teachings of major religions. In Sri Lanka, the predominantly Buddhist culture has had a tremendous influence on the society and it continues to shape the way people look at human relations and sexual matters. With the emergence of Acquired Immuno-deficiency Syndrome (AIDS) and the increased incidence of sexually transmitted diseases (STDs), it became necessary for various groups to discuss the subject of sex and sexuality more openly to find ways of combatting these diseases. However, to date, in Sri Lanka, there had been little work done towards trying to develop a culturally appropriate strategy to interrupt the transmission of the disease.

Sarvodaya, which has always underscored the importance of spiritual values in all spheres of human development, and which has especially had considerable experience in mobilizing the Buddhist clergy for community development, through a project funded by WHO titled "Towards a Buddhist approach to AIDS prevention in Sri Lanka", a methodology was developed to involve the Buddhist monks in AIDS prevention and control at community level. The project succeeded in breaking the resistance that prevails regarding the involvement of clergy in a sensitive subject which has aspects related to sexuality and sexual behaviour. Using the very same teachings found in Buddhist literature, a training module was developed, pre-tested and over 1500 Buddhist monks from 5 districts were trained. It is intended to initiate temple-based, culturally appropriate, scientifically planned, AIDS prvention programme through the leadership of the trained Buddhist monks. Educational material on AIDS based on Buddhist teachings were developed and AIDS

Adressing psycho-social problems among children exposed to armed violence

The psychological and psycho-social effects on children in war and other violent situations have been well documented internationally. In Sri Lanka, the armed conflicts since 1983 represent the single most debilitating and pervasive factor affecting the lives of children and women. Many children in Sri Lanka have witnessed the death or disappearance of family members and friends in the North and East conflict and during the Southern insurgency in 1987-89. Although accurate data is not available, it is estimated that over 500,000 children are directly or indirectly affected by the on-going conflict in the North and East. The negative impact of the war on children in terms of their physical and psycho-social development is evident from the available date.

Whereas, despite the ongoing conflict, the physical health needs of children have received considerable programming and attention, the psychological status of Sri Lankan children affected by war and armed conflict has received relatively little formal study or attention. Government and non-government programmes are directed to social welfare interventions and the standard health and educational services give little or no consideration to the psychological status of the child in their routine programming.

Through a project funded by the USAID, Sarvodaya is currently implementing a comprehensive programme to address the problem through a community and family centred approach by; directly providing support to the children in the target communities using culturally appropriate healing processes, creating an awareness among community leaders, training school teachers and selected community workers on methods of identifying psycho-social problems among the children and ways of addressing them, and through the development of simpler assessments methodology to identify children who may require additional psychological support.

6. The Present Challenge

As stated earlier, inspite of a seemingly extensive health infrastructure, ill-health continues to take its heavy toll in Sri Lanka. At the same time, it is well accepted that no amount of effort by government health services or health workers alone is likely to bring any substantial effect. Moreover, root causes of ill-health are poverty and powerlessness. Thus, Sarvodaya's approach has been to create a village level infrastructure base where an integrated self-help programme of development could take place in the most deprived and underprivileged communities in Sri Lanka. This is not to imply that certain medical interventions such as immunization, ORT etc. are of no importance (in effect SSM has actively promoted all of them in its programmes), but rather, the full value and benefits of such interventions in terms of improving health status can only be realized within a much broader socio-economic and political framework.

The existing community health programmes in Sri Lanka have met the problem of physical isolation of villages and poor communication and infrastructure services in many regions. The government has also realized that it is very difficult to serve these communities through a traditional top-down hierarchical health care structure. The logistics and costs make a government funded health service impossible. Furthermore, the government health workers have a conflicting commitment to the community and to the hierarchy of their superiors. They have not identified themselves with the problem stricken communities. As a result,

experience shows that there were many village communities who were not aware that services provided by the government were even available to them. Sarvodaya has demonstrated that through self-help methods this gap can be filled and health improvements effected. Other NGOs attempting to do this have also found the scale of the problem in addressing the needs of villages through out the island prohibitive. They also face the problem of initial acceptance by the village community, which may take some time and the on going presence needed to monitor results and implement training a difficulty.

As Gunatiilleke (1985) observes, *"Sarvodaya Movement was able to expand its activities and promote a community based programme of village development that was genuinely participatory; it included an important component of child and health care. However, voluntary activities on the whole had invariably been from top down with hardly any effort to create and enhance the community's own capability for improving health, sanitation and nutrition. This is partly because of the failure to institutionalize the process of community participation through strong village-level institutions".*[18]

However, while Sarvodaya has succeeded in institutionalizing a holistic development process at village level through the creation of independent legally registered village societies, it has felt that the fullest potential of these grass-roots entities is yet to be realized in the area of community health.

There is a general reluctance on the part of the field workers to enter too much into health programmes out of a fear that such activity might antagonize the government health workers. In a country where a heavily "medicalized" health care system is in place and where health professionals enjoy a considerable social status, such fears are understandable. They fear that organizing the community around health issues might undermine the existing relationship between the community and the formal health care system (no matter how ineffective that relationship is in addressing felt health needs of the community!).

The need is not only for the community understand their health situation better, but also for the government health workers to also re-think and re-define their role in the community. The Sarvodaya Movement has been able to maintain this difficult balance with the community and the formal health system by way of persuasion and building a mutual trust with the grass-roots government health workers. There is enormous potential for this relationship to further develop for community action towards promoting health.

Sarvodaya has to date facilitated the formation of well over 2500 independent village level societies which have now come-of-age and matured into dynamic bodies capable of responding to growing challenges affecting the lives of the community members. There is a growing demand and interest among these village societies to embark on comprehensive community health programmes.

Furthermore, in Sri Lanka's present context of rapidly changing economic policies within an open market economy, the correct assessment of environmental health risks at community level is of paramount importance. It is the only way that vigilance can be kept over profit oriented investors establishing hazardous enterprises and projects that would have a detrimental effect on the community's health.

The experience of Sarvodaya in Sri Lanka and that of similar initiatives from all over the world support the fact that, given the proper guidance and tools, the communities are capable of managing their own affairs. The conventional belief that the poor in the developing world are incapable of dealing with environmental health risks or have no interest in doing so, is no longer valid; "the contribution that the poor can make to solving these problems must not be overlooked. Individuals and communities already live and cope under formidable circumstances, attesting to their knowledge of environmental problems and skills to survive".[19]

7. Future Prospects

The need in Sri Lanka for a more comprehensive understanding of community health problems and more active participation of the communities in planning interventions is clearly evident. The most effective approach towards this end is to make community organizations responsible for their own village health programmes. The emphasis should therefore be - for the communities to develop partnerships; with the government, NGOs, and the private sector to support their own efforts to improve health care. For this to happen there is a need to strengthen these village organizations in their capacity to plan, implement, monitor and evaluate health programmes. This would not only ensure optimum use of community resources but also long term sustainability. This involves correctly assessing the health problems in a given community through collection and analysis of health data using suitable methods for villagers to perceive health risks in their environment; a case for community epidemiology and for use of health information at the community level.

While the community itself plays the primary role in their own health programmes, it must also rely on others, especially the government health services for some important complementary services. There must also be a balance between curative and preventive programmes. Communities cannot develop sustainable health programmes entirely on their own. Leaving everything to the community is a mis-interpretation and undermining the true meaning of PHC.[20] For services such as immunization, family planning, and treatment for example, the community has to turn to the state health services. It implies that, while the community collectively identifies health problems and vulnerable sub-groups in the village and initiates some action, there should also be an effective mechanism for the community to relate to the health system and other sectors where indicated. This is in line with a basic principle in Sarvodaya. Sarvodaya not only enables the deprived communities to understand their situation and to initiate their own decision making process, *but it also provides them the ability to carry out such decisions into effective actions*. This is where the difference lies between Sarvodaya and other organizations and academic institutions which carry out "participatory" research and community assessments as a one time exercise.

The Sarvodaya infrastructure from the national level to the grass-roots forms an available, effective and proven basis for meeting the health challenges of the 21st century. The village level Sarvodaya Shramadana Societies and the grass-roots level Sarvodaya workers have clearly demonstrated their willingness and ability to acquire the necessary knowledge and skills to take up the challenge through an integrated and sustainable approach to community health.

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